Briefing

Development Research Centre on Migration, Globalisation & Poverty

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# Human Resources For Health And Migration: Mobility, Training and the Global Supply of Health Workers

## Summary

*This briefing presents findings from the Workshop on Human Resources for Health and Migration: Mobility, Training and the Global Supply of Health Workers held at Sussex, 16-17 May 2007, and identifies policy-relevant conclusions and topics for further research. It builds on briefing No. 6, Skilled Migration: Healthcare Policy Options published by the Migration DRC in March 2006, which can be found at http://www.migrationdrc.org/publications/riefing_papersBP6.pdf*

## Overview

Migration can too easily become a scapegoat for the woes of poorly performing health systems. A strong case is made by many researchers that, although negative effects following the migration of health workers from developing countries can exist, other factors are likely to be as, if not more, important than emigration. That is, migration is not the underlying problem in the human resource crisis in the health sector of developing countries. Nor is migration likely to be the long-term answer to shortages of health workers in the developed world.

Effective policy must therefore focus not on curbing movement but on creating conditions that make it possible for human resources to thrive and be effective where they are needed most. An individual's right to move needs to be safeguarded; restricting or stopping avenues for mobility will only push migrants into irregular channels, making it difficult for them to practice their skill, and also making them vulnerable to exploitation. Instead, investments need to be made in training globally. Human resource strategies need to be planned in both developed and developing countries so that shortages can be addressed in both areas. While the migration of health professionals cannot and should not be stopped, programmes that specifically target personnel from the poorest countries by richer countries need to be reassessed.

## Geographical Distribution

Any assessment of the impact of the exodus of health personnel needs to examine their distribution within the countries of origin. The majority of doctors and nurses in developing countries tend to be concentrated in the capital city or at least the main urban centres. Fully two-thirds of the doctors in Ghana, for example, are to be found in the two largest towns of Accra and Kumasi. The health personnel are generally not to be found in the areas of greatest need. Although the counterfactual must remain unknown, there seems no reason to believe that, had the doctors and nurses not left the country, they would have gone instead to the more marginal parts of that country. Hence, neither the exodus of doctors, nor the prevention of that exodus, are likely to have a significant impact on the health status of the population in areas of greatest need. It is in the marginal, rural areas where an improvement in basic indicators will be most likely to have an impact on the overall wellbeing of national populations. Often, developing countries can only provide basic health services in rural areas by bringing professionals in from other developing countries such as Cuba, or from the North through aid programmes or NGOs.

## Disaggregation of Information on Health Workers

Most of the available data on skilled health workers refer only to “doctors” and “nurses”, which has meant that the concern about migration has been focused on these categories as complete entities, with particular attention given to recognition of qualifications, international standards of training and career structure. However it is important to look beyond the aggregated data on doctors and nurses to unpick the effect of particular specialisms in the

Nurse assistant in Santa Domingo ©IOM

health sector, as well as other types of worker that can impact on the health of a population, such as lab technicians, pharmacists and public health officers.

## Training and Skills

All countries need to consider expanding existing training services to meet local demands for health professionals. However, the training of doctors in particular is expensive and is subject to considerable wastage. The graduates are able to enter global markets and are likely to move to where remuneration is high and conditions are better. Even when countries attain relatively high levels of development, leakage can be expected. Doctors leave the UK for the United States, Australian doctors come to the UK, and so on. Nevertheless, increasing the number of trained professionals in any country is likely to increase the pool within that country, despite leakages, as not all professionals will either want or be able to migrate. It is also important for destination countries to address the issue of skills wastage, when migrant doctors encounter barriers that prevent them from working.

As well as concern over global stocks of trained health prof-essionals, the issue of the most appropriate training for local needs exists. That is, training most likely to contribute to the reduction in infant and maternal mortality in a population, key indicators of the MDGs. Highly trained professionals, who can only use their skills productively in advanced hospitals, may not be the best health personnel for areas with few modern amenities. Programmes to train larger numbers of people in basic skills may provide a better and more cost-effective way to achieve the MDGs than just concentrating on expensive training that can be effectively applied only in urban areas. Even in areas with high concentrations of people with HIV/AIDS, health workers with basic medical skills can make a significant difference.

Training centres to teach basic skills are likely to achieve greater success if they are located in small towns in the more marginal areas of a country and recruit trainees locally. The graduates from such centres are not marketable internationally and are less likely to seek to go overseas. However, the opportunity must always exist to allow those who have been so trained to upgrade their skills if they wish, to ensure that they are not permanently locked into a lower-tier health delivery system. No country wishes to be seen as having a "second-rate" medical system.

**Box 1 :**
**Malawi's Emergency Human Resources Plan**
This programme is a partnership with actors such as DFID, Global Fund to Fight AIDS, TB and Malaria, WHO and the African Development Bank to increase the remuneration for health workers, create incentives to work in rural areas, bring back professionals from outside the country and strengthen local training capacity. While some evidence exists that the exodus of health professionals has slowed and more doctors are being trained, there are still vacancy rates of over 40% and high attrition from AIDS, and progress with infrastructure is slow.

## Partnerships

Policies and programmes implemented in either country of origin or country of destination alone are unlikely to be sufficient. Some kind of joint framework will be needed if the movement of skills is to be managed. These frameworks may be bilateral or multilateral and each may also incorporate support from private donors such as the Gates Foundation or the Clinton Foundation. Some examples of these programmes are already underway, such as the partnership between the Netherlands and Zambia or DFID's six-year programme with the government of Malawi (see Box 1). Twinning between institutions in the developed and developing world can also help to promote centres of excellence in countries of origin through the secondment of staff and the design and implementation of short training courses.

At the multilateral level, the Global Health Workforce Alliance (GHWA), a partnership hosted and administered by the World Health Organization, provides a forum for governments, NGOs, international organizations, donors, academic institutions, professional associations and workers to search for solutions to the current "crisis" in health workforce. This partnership not only provides a forum that allows dialogue among the various actors to generate a high profile for the issues but also can work towards the establishment of common definitions and standards, and the gathering and sharing of data that are fundamental to achieving better solutions. While global partnerships are to be welcomed, regional collaboration, too, will provide areas of agreement where groups of countries are faced with common problems.

## Role of the Private Sector

There is a complex and growing role for the private sector in health care and the provision of training. Both training in health care, and health care delivery, have largely been public sector endeavours, particularly in developing countries, and the limitations on the public sector in recent years has particularly affected poorer sections of populations that do not have the resources to seek private care. The private sector is also a growing destination for doctors and nurses leaving the state-funded health sector. On the other side of the coin, in some countries such as India, the Philippines and South Africa, private training colleges for nurses have significantly boosted the numbers of trained staff produced, often in response to specific migration opportunities. The role of the private sector is as yet poorly understood in terms of its effect on health systems and a number of research opportunities exist to consider its relationship with migration. These include:

- Making health work in the origin country more attractive by providing a mix of private and public sector opportunities to doctors and nurses
- The effect on origin-country health services of the provision of private training
- The loss of the most experienced medical personnel may prejudice the training of the next generations of health workers and private training might provide one avenue to retaining more of these key trainers.

## Return and Circulation

In countries that perceive the high out-migration of health professionals as an issue, a desire exists to see a greater return and circulation of those who have left. In addition, some destination countries and international organisations are interested in the contribution to development that the diaspora could bring to the countries of origin. That is, health workers from any developing country who are overseas might be organised in some way to promote the development of the home country. The investment of remittances is one well-examined channel, but long or short term return to work in the home area may also be another way that migrants can contribute to their country of origin. We need a better understanding of whether and when migrant health workers are returning, under what circumstances they return and whether they are integrated back into the health sector on return. More information is also needed about the contribution health workers make before their departure. What is the length and type of service they provide before they go and how vital is this? In terms of short term return, the numbers currently involved in circulation programmes appear small, but what is the situation outside these organised programmes and do they offer a good model for the future?

Returnee doctor in Afghanistan ©IOM

**Box 2 : Policy Options**

- Job regrading (Uganda)
- Separate Ministry of Health/Central Board of Health (Zambia)
- Salary supplements (Malawi)
- Remote-area incentives (Zambia)
- Car/housing loans (Ghana)
- Decentralisation of recruitment (Kenya)
- Contracting out recruitment (Namibia)
- 'Treat, train, retain' for health workers (WHO)
- Flexible working (Malawi)
- Rethinking the skills mix of the workforce - mid level workers (Ethiopia, Uganda)
- Task-shifting (Malawi, Mozambique)
- Investment in training institutions in rural areas (Tanzania-all cadres)
- Building centres of excellence (India-Public Health)

Source: DFID presentation at Migration DRC workshop on Human Resources For Health And Migration: Mobility, Training and the Global Supply of Health Workers, 16-17 May 2007

## Policy Options

This briefing looks beyond the traditional concerns about the 'brain drain' of medical personnel to also address concerns about internal supply, distribution and retention. These two approaches are closely linked but the policy options to address them may look very different. In the 'brain drain' approach, the main policies are about preventing 'poaching' through bilateral or international ethical recruitment policies, preventing the departure of specific workers for a period through bonding, or small-scale managed return programmes. Internally, most attention and investment

has traditionally been in training, often a pre-service, possibly outdated model. In- service incentives are often focused on salary supplements which may have a negligible impact at best and can disrupt service delivery at worst. There has been little attention to HR planning, recruitment and deployment processes or HR information where there is likely to be scope for improvement and very little attention has been paid to retention. There are some examples - detailed in Box 2 - of more imaginative policies being trialled.

When looking at human resources for health, focusing on migration alone is likely to produce a distorted view. The movement of health professionals will not slow with increasing levels of development: developed countries, too, experience the departure and circulation of doctors and nurses. Policies and programmes to improve human resources in the developing world will have to adopt a multi-pronged approach, the management of the movement of health professionals being but one part. This management should not be to restrict the migration of health personnel but to try to ensure that enough personnel are in the places where they are needed most, which means that, over the short term, more staff will need to be shifted into rural areas.

To achieve that objective, the emphasis needs to be placed on training to increase both the number and the quality of personnel available but also the appropriateness of that training. The emphasis on training reintroduces the importance of skills other than just in health. Education and teachers are fundamental to any improvements in training and it is already becoming clear that some centres of excellence are emerging in areas outside the traditional developed world - in Africa, Asia and Latin America - a trend that can be expected to continue. These regional centres might create the skills needed, not just within their own regions, but also globally.

## Further Key Readings

Clemens, M. (2007) 'Do visas kill? Health effects of African health professional emigration', Centre for Global Development, Working Paper no. 114
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C. Farthing, H. Lu, W. Xu, D. Lui and Y. Cao (2006), *Training doctors in developing countries* - a twinning project between ARF, Los Angeles, and the SPHC yields results and provides a model, AIDS Healthcare Foundation, Amsterdam.

Report of the Migration DRC, *Workshop on Human Resources for Health and Migration: Mobility, Training and the Global Supply of Health Workers*, 16-17 May 2007, http://www.migrationdrc.org/news/reports/mobility/index.html

Joint Learning Initiative (2004), *Human Resources for Health: Overcoming the Crisis*, Harvard University Press, Cambridge (MA).

## Development Research Centre on Migration, Globalisation and Poverty

The Migration DRC aims to promote new policy approaches that will help to maximize the potential benefits of migration for poor people, whilst minimising its risks and costs. It is undertaking a programme of research, capacity-building, training and promotion of dialogue to provide the strong evidential and conceptual base needed for such new policy approaches. This knowledge base will also be shared with poor migrants, contributing both directly and indirectly to the elimination of poverty.

## How to Contact Us

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